STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	01/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

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F0000	This visit was for the Investigation of Complaint IN00122567. Complaint: IN00122567 Substantiated. Federal/State deficiencies related to the allegation is cited at F323. Survey dates: January 23, & 24, 2013 Extended Survey dates: January 28 & 30, 2013 Facility Number: 000105 Provider Number: 155198 AIM Number: NA Survey Team: Mary Jane G. Fischer RN Census Bed Type: SNF: 87 Residential: 53 Total: 140 Census Payor Type: Medicare: 40 Other: 100 Total: 140 Sample: 5 Supplemental Sample: 13	F0000	No response necessary for this tag	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality Review Completed by Tammy Alley RN on 2/4/2013.			

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F0323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure the safety of confused and dependent residents, in that when resident's were dependent upon staff for supervision and determined to have a cognitive impairment, the nursing staff failed to ensure residents received adequate supervision to prevent accidents which resulted in severe lacerations, abrasions and bruising for 5 of 5 sampled and 4 of 13 supplemental sampled resident's reviewed for lack of supervision which resulted in injury. (Resident's "A", "B", "C", "D", "E", "L", "Q", "R" and "S"). In addition the facility failed to implement their policy in which residents who were identified as a fall risk were monitored through specific signage for 10 of 10 supplemental sampled residents. (Resident's "G", "H", "I", "J", "K", "L", "M", "N", "O", "P"). Findings include:	F0323	The creation and submission of this plan of correction does not constitue as a n admission of any conclusion set forth in the statement of deficiencies or any violation of regulations. F 323· *What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* A new Fall Assessment was completed on Resident A, B, C, D, E, G, H, I, J, K, L, M, N, O, P, Q, R and S. Appropriate interventions were implemented and each care plan was updated. Resident Information Sheets were also updated.· *How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?* An extensive audit was conducted. New Fall Assessments were completed on all residents in the Health Care Center. All care plans were reviewed and updated as necessary for all residents identified as being at risk for falls or having a history of falls. Resident Information Sheets were also updated. · *What measures will be put into place or what systemic changes will be made to*	02/25/2013

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	1. The record for Resident "A" was reviewed on 01-23-13 at 1:00 p.m. Diagnoses included but were not limited to, Alzheimer's dementia, depression, congestive heart failure, difficulty in walking and peripheral vascular disease. These diagnoses remained current at the time of the record review. The resident's "Fall Risk Assessment," dated 03-08-12 indicated the resident was at "high risk for falls," with a total score of "10." A notation on this risk assessment, indicated a score of 10 or greater identified the resident at "High Risk" for falls. Review of the resident's MDS (Minimum Data Set), Annual assessment dated 05-24-12, and Quarterly assessment dated 11-07-12, indicated the resident had "severe cognitive impairment, was not able to balance self without staff assistance in moving from a seated to standing position, walking, turning around, moving on or off toilet, and surface to surface transfer." In addition the resident was assessed with impairment to "one side of the upper extremity, and both lower extremities."		*ensure that the deficient practice does not recur?* The Fall Prevention and Management policy and the Falling Star program have been revised (see attached)All Health Care Center staff will be in-serviced on the revised Fall Prevention and Management policy and the Falling Star program. (See attached schedule)All licensed nurses will be in-serviced on the accurate completion of fall assessments, including implementation of appropriate interventions and updating of care plans.Nursing Management will audit the Treatment Administration Record (TAR) to ensure alarms are being verified for placement at least twice weekly.Activity staff will be in-serviced regarding the need to provide meaningful activities for at risk residents. · *How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place* Nursing management will conduct an audit five (5) times a week of all new residents to identify fall risks and/or history of falls. (See attached audit sheet)The Interdisciplinary Team (IDT) will conduct a post fall assessment following each fall. Nursing management will conduct an environmental round at least twice a week to ensure interventions ot prevent falls and care plans are being	

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	The resident's current plan of care, originally dated 06-06-12, indicated the resident had "poor memory recall abilities with impaired decision making skills and poor safety awareness." A subsequent plan of care, noted as "active through 02-15-13," indicated, "I am able to bear weight but I become unsteady during transfers and ambulation and need staff support. My safety awareness is poor because of my impaired judgement and I will need cues and reminders throughout each shift. I am at risk for an injury if I fall because I have osteoarthritis." The "goal" to this plan of care indicated, "I do not want to have a fall with injury through the next review." Nurses note, dated 08-24-12, at 11:48 p.m., indicated, "Resident was found in t.v. [television] room during activity at approximately 1600 [4:00 p.m.], lying face down on the floor in front of wheel chair. Res. [resident] was crying and noted large hematoma on left forehead. Area was not actively bleeding but had already started to bruise. Res. is unaware of how [resident] fell. Res. was alert to self as per usual self ice		followed. Nursing management will conduct an audit at least two (2) times a week to ensure nursing assessments have been accurately completed for all residents within MDS guidelines. Administrator and/or Activity Director will conduct audits at least twice weekly to ensure that residents at risk for falls are included in activity programming. Activity staff will obtain daily Resident Information Sheets for most current resident information. Information gathered from the audits will be forwarded to the Quality Assurance Committee to determine a future auditing schedule. · *By what date the systemic changes will be completed?* February 25, 2013	

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	placed on forehead and assisted resident back into chair. [Name of physician] was in building and looked at res. for nurse and she [in reference to the physician] felt that res. needed X-ray of head because she could feel an area that was indented." Nurses note, dated 08-25-12 at 1:46 a.m., indicated, "Lg. [large] raised/bruised area noted L [left] forehead; area abraided. Very painful to touch, esp. [especially] the indented area." The resident received an Occupational Therapy Evaluation, dated 09-25-12, and a Physical Therapy Evaluation, dated 09-26-12, in which both disciplines indicated the resident was "Fall Risk." The resident's plan of care lacked a current intervention in regard to the resident being "found" by the nursing staff, left unattended, in the activity room. The 11-07-12 "Nursing Evaluation," indicated the resident had "chronic confusion, altered perception, "no falls in the past 3 months," uses a personal alarm, and had a "fall risk score" of "14."			

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	Review of the Reportable to ISDH, with a dated incident of 01-9-13, indicated the resident "fell out of chair - reaching for an item. Unwitnessed fall. Resident in W/C [wheel chair] in dining room. Attempted to get up on own, fell forward out of W/C and hit forehead on floor. 3.0 centimeter skin tear to left lower forearm and 2 lacerations [6 centimeters and 3 centimeters] to forehead." The facility "Event Report, dated 01-09-13, indicated, "Resident in dining room, no staff present." The resident was transported to the local hospital emergency room, where the resident received treatment. A Medical Imaging report, dated 01-09-13, with a CT (Cat Scan) of Brain/Head indicated: trauma, scalp injury - reconstruction was performed." A physician progress note dated 01-11-13, indicated, "Hx [history per staff] - Pt. [patient] sent to ED [Emergency Department] on 01-09-[13] after fall. Sitting at dinner, fell and hit head on edge of table. [Resident] required 2 deep absorbable sutures along with 6 additional sutures. Due to skin fragility it was difficult]to approximate well. Steri strips applied as well. Per			

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	nurse, no bleeding issues and pt. [patient] has has been fine not requiring additional pain meds besides those already scheduled prior to incident. Approximate 8 cm [centimeter] laceration across forehead with another 3 cm. extension off the left lateral end. Steristrips in place. Old, dry blood. Poorly approximated." A subsequent physician progress note dated 01-14-13, indicated the following: "F/U [follow up] on above. Per nursing area to forehead is healing. Nursing reports no change in mental states, appetite or mood. I spoke to DON [Director of Nurses] about the fall and she states pt. was in wheel chair in dining room facing away from the table. One therapist in the dining room at time of fall but did not witness. Therapist turned to assist another resident and heard fall, turned around to find [name of resident] on the floor, there was no table between pt's w/c and where [resident] fell. It is assumed that [resident] struck head on floor only and nothing else in the line of the fall. Pt. also reportedly c/o[complained of] knee pain since fall, has h/o [history of] OA[(osteoarthritis]."			

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After the resident sustained a fall with injury, the nursing intervention for the resident was the use of a Dycem [a device placed on the wheel chair to prevent the resident from slipping out of the wheel chair] on the wheelchair. The record lacked intervention to alert the staff of unassisted transfer or attempted ambulation.

Observation on 01-23-13 at 10:00 a.m., the resident was seated in a wheel chair. The resident's left forehead had a bandaged dressing over a raised area. Beneath bilateral eyes was resolving bruising which was gray/yellow in color.

Observation on 01-23-13 at 12:15 p.m., 01-24-13 at 12:30 p.m. and 01-28-13 at 12:10 p.m., the resident did not have a personal alarm.

Interview on 01-23-13 at 12:00 p.m., the Unit Manager Licensed Practical Nurse employee #5 indicated the resident "didn't use an alarm or sensor pad" to alert the staff of unassisted ambulation or transfer.

Interview with a concerned family member on 01-24-13 at 8:15 a.m., indicated a "worry" that (name of resident) could "fall and have a head

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	injury in August" and the facility didn't "put anything in place, and didn't even provide enough supervision to get to [resident] before the this last fall." 2. The record for Resident "B" was reviewed on 01-24-13 at 11:30 a.m. Diagnoses included but were not limited, to hypertension, coronary disease, and thrombocytosis. These diagnoses remained current at the time of the record review. The resident was admitted to the facility for Rehabilitation Therapy Services. A "Fall Risk Assessment," dated 09-20-12, indicated the resident was "alert with acute confusion and oriented to person" and "not" a fall risk. The MDS, dated 09-27-12, indicated the resident was cognitively alert, but had problems with balance in which the resident needed the assistance of the staff to rebalance in regard to moving from a seated to standing position, walking, turning around, moving on and off the toilet and surface to surface transfers. In addition, the assessment indicated the resident required extensive assistance with transfer, bed mobility, and toileting and one staff member.			

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	Review of the Nurses notes, dated 11-06-12 at 4:19 a.m., indicated, "At 0200 [2:00 a.m.] res. was transferring with assist times 1 to get up to the bathroom. During transfer, resident said "felt weak and could not stand," so along with the aid [CNA Certified Nurses Aide], slowly lowered self to the floor." A Nurses note, dated 11-20-12 at 2:00 p.m. indicated, "Res. found on BR [bathroom] floor per writer. BR call lt. [light] going off. Back of W/C to front of sink. Left side of chair brake not locked. Res. laying on floor tilted to right side. Res. stated hit right side of head and right hip. No bruising or swelling noted to these areas. States was transferring self from commode to chair. 'My legs gave out.'" Nurses note, dated 12-08-12 at 1:42 p.m., indicated, the "Resident tearful this AM," and expressed "I am just so confused. When writer oriented res, res, stated 'I know why I'm here.'" Nurses note, dated 12-11-12 at 10:05 a.m., indicated, "found on the floor face down at 9:35 a.m. No change with LOC [level of consciousness], with multiple skin tear [sic] right knee 9 cm [centimeters] by 4 cm, Left knee			

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	3 cm, L knee 1 cm by 1 cm, above right eye 6 cm by 4 cm, on right chick [sic] 5 cm by 2 cm, right shoulder 4 cm by 4 cm. Pressure dressing forced on forehead [sic], knee and sholder [sic]. Res. to ER [emergency room] for treatment and eval. [evaluation)." The hospital "wound/skin evaluation," dated 12-11-12, assessed the resident's injuries as follows: "#1 - right forehead - partial flap with sutures just above eyebrow - 4 cm by 2.4 cm with ecchymosis." "#2 - right cheek 3 cm by 2.2 cm - skin tear." "# 5 - skin tear 7 cm." "#6 right knee distal 6.5 cm by 4 cm - skin tear." Review of the hospital discharge summary, dated 12-12-12, indicated the resident was admitted to the hospital "after falling at the skilled nursing facility. The patient fell and hit head and also had some wounds to right knee, left knee and right eye periorbital and forehead. The patient is stable and is hesitant to return back to the skilled nursing facility due to			

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	this fall." The "Fall Risk Assessment," dated 12-12-12, indicated the resident was now alert and oriented to person and "not" at risk for falls. 3. The record for Resident "C" was reviewed on 01-23-13 at 1:50 p.m. Diagnoses included but were not limited to, congestive heart failure, hypertension, macular degeneration, lung cancer, pacemaker placement and chronic kidney disease - stage 4. These diagnoses remained current at the time of the record review. The resident was admitted to the facility on 10-18-12. The nursing admission evaluation dated 10-18-12 indicated the resident had no behavior problems, no cognitive impairment with modified independence, no confusion but did exhibit impaired safety awareness. The "Fall Risk" score was "4" and not considered a "fall risk." Review of the current plan of care dated 10-26-12, indicated the resident was "at risk for falling due to impaired balance and new surroundings" and "experiencing some periods of acute confusion and can be resistant to caregivers at times."			

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	Review of the "Skilled/Non-Skilled Nursing Clinical Review," dated 10-21-12 indicated the resident was "alert and oriented to person, place and time, no behaviors noted, cooperative, gait unsteady." The "Skilled/Non-Skilled Clinical Review," dated 10-23-12, indicated the resident displayed a "continued unsteady gait," but now included "weakness - bilateral." A subsequent MDS assessment, dated 11-07-12, indicated the resident displayed memory problems and moderate cognitive impairment. The "Skilled/Non-Skilled Clinical Review," dated 11-09-12, assessed the resident as "decreased social activities, cooperative but withdrawn, decreased grasp - left and right," and a subsequent clinical review, dated 11-11-12, the resident's cognitive status had declined and was "alert" but only "oriented to person - dwells on illness/other problems, weakness - bilateral weakness - unilateral." The "Skilled/Non-Skilled Clinical Review," dated 11-12-12, indicated the resident was now "lethargic."			

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	Review of the plan of care dated, 11-13-12, indicated "I am at risk for falling due to impaired balance and new surroundings." Interventions included "provide limited assistance with transfers as needed, assist to wear non slick footwear that fits, instruct on safety measures to reduce the risk of falls, keep areas free of obstruction to reduce the risk of falls or injury, keep nurse call light within easy reach. Instruct to use call bell or call out for assistance." A subsequent plan of care, noted as "current through 02-28-13," indicated the resident was "experiencing some periods of acute confusion and can be resistant to care givers. This is not my usual personality. I am also experiencing some cognition decline and also have very poor hearing which causes me to not understand caregivers at times." A physician order dated 11-19-12, instructed the nursing staff, "Hospice to evaluate and treat." An 11-24-12, Hospice nursing note documented a "phone call to [family member] and discussed concerns. One concern was pt. being taken to bathroom by staff. [Family member] feels pt is too weak to safely			

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	ambulate by self and [resident] does not remember to use call light. Talked to [name of facility licensed nurse] who agrees and has instructed CNA's to toilet pt q [every] 2 hours and to encourage daily baths." Review of the resident "Clinical Notes Report," were as follows: 11-24-12 and 11-25-12, identified a change in the resident's cognitive abilities, with "delusions/hallucinations" prior to the beginning of Hospice services and ongoing notation of family concerns related to the resident's safety. "11-24-12 2:48 p.m. Appetite poor. Res. up to BR [bathroom] per self. At times, res. removes O2 [oxygen] to go to BR at times. Res. talking out at times and reaches into air with arms. [Family member] reports res. more confused this afternoon. Res. spoke of little children in the room." "11-25-12 at 2:30 p.m. Res. alert to name and place. Intermittently has periods of lucidity and confusion/delusions. 'Get me out of the fire ! ... Cut this !' Res. clutching O2 nasal cannula before neck. Assisted res. to dress in 'day clothes'. 'I don't know why I have to get			

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	dressed. My pajamas are warm.' Res. wearing two shirts and then covered with light blanket per request. Family expressing concern regarding res." "11-25-12 at 7:01 p.m., Resident was lethargic before evening shift stated, sitting in the w/c. Family in to visit around 2:30 p.m. Put resident in bed. Family had concerned [sic] why resident is so lethargic ? According to report from previous shift nurse, resident up all night. Family was very anxious and request to call the hospice nurse. Writer told resident to eat dinner, res. said, 'I want cereal,' writer reasure [sic], this is dinner time. Res. again said 'I want cereal,' so one of the CNA [sic] brought cereal. After awhile nurse went to check either [sic] resident ate meal or not. Resident lying on the bed and naphking [sic] is on the plate. Writer ask [sic], did you eat meal {name of resident] ? Resident said, 'you put poison in meal, shut up and go out right now.' Resident looks very agitated." "12-01-12 at 7:00 a.m. Resident fell at 3:45 a.m. witnessed by nurse. Resident scraped the bridge of nose on the bedside table sustaining a skin tear with small amt. [amount] of bleeding. Has been slightly restless.			

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	Refuses to use call light which is in reach to request assist from staff. Resident assisted to the bathroom by nurse and gait was very unsteady. First Aid applied to bridge of nose, cleansed with NS [normal saline] and steristrips applied after bleeding stopped." The 12-01-12 notation, indicated that at 7:45 a.m., the resident had steri strips applied to the nose and also now was assessed with an "abrasion above the left eye brow." During interview on 01-24-13 at 1:00 p.m., the Director of Nurses indicated when the resident was started on Hospice due to a significant change in condition an assessment was to be completed. When requested to review of the Significant Change MDS and the "Fall Risk evaluation/assessment" associated with the Significant Change in Condition, the Director of Nurses indicated "I won't lie to you I can't find one." When further interviewed what the facility put in place after the family member expressed concerns on 11-24-12, and as the resident's condition continued to decline, the			

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	Director of Nurses indicated she couldn't "find anything." 4. The record for Resident "D" was reviewed on 01-23-13 at 12:40 p.m. Diagnoses included but were not limited to, dementia, depression, anxiety, abnormality of gait, and a history of falls. These diagnoses remained current at the time of the record review. The record indicated the resident had been admitted to the facility from a secured dementia unit. Review of the resident's MDS, dated 01-24-13, indicated the resident had severe cognitive impairment, with both short term and long term memory loss and also indicated the resident was not able to balance self without staff assistance in moving from a seated to standing position, walking, turning around, moving on or off toilet, and surface to surface transfer. Review of the resident's plan of current, noted as "current through 02-15-13," indicated, "I am at risk for a fall with injury due to my impaired safety, awareness. I attempt ambulation and transfer unassisted." Interventions to this plan of care			

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	included "sensor pad to W/C at all times." A "Fall Risk" assessment dated 03-18-12, indicated the resident was at High Risk for falls with a total score of "16." Review of the current Resident Care Information sheet on 01-23-13 at 11:30 a.m., indicated the resident had a "sensor pad" not only to wheelchair but also to "low bed." A physician order dated 03-20-12 instructed the nursing staff "sensor pad to wheelchair at all times." Nurses Notes indicated the resident had been found on the floor/identified with a falls on 12-28-11, 12-30-11, 01-01-12, 01-25-12, 01-26-12, 01-28-12, 02-03-12, 02-13-12, 03-11-12, 03-15-12, 11-10-12, 12-31-12 and 01-24-13. The Nurses notes, dated 01-16-12 indicated IDT (interdisciplinary; team) review of falls. "Fall on 12-28-11, 12-30-11 and 01-01-12. Staff education - sensor pad to w/c." "01-25-12 12:00 a.m. - Found resident sitting up on floor in room. neurochecks initiated."			

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	"01-28-12 11:30 - Resident found on floor in room by w/c. Res. attempting to get in bed at the time. Unwitnessed." "02-03-12 9:40 a.m. Resident attempted to transfer self from w/c. W/C at foot of bed. Unable to ambulate - fell onto floor." "02-06-12 10:30 p.m. IDT review for falls. Fall 01-26-12 and 01-28-12 at 12:00 a.m. on 01-26-12 - found scooting on floor. Therapy screen on 01-25-12 at 11:30 a.m. Found on floor - sensor pad on w/c when available." "02-13-12 11:30 p.m. - Res. observed in hallway on buttocks scooting using hands. Stated 'I need to go to Chicago to play the piano for the wedding at midnight.' Attempted to re-orient res. to time of day and weather conditions. Res. stated 'I'll take the train.'" "02-21-12 2:00 p.m. IDT review for falls. Fell on 02-03-12. Self transfer from W/C." "03-11-12 4:45 p.m. Found supine on floor room [number documented]. W/C behind resident."			

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	"03-15-12 10:00 p.m. Res. had fall at 4:15 p.m. Res. was in activity room in W/C No staff witnessed fall, but found res. lying on back next to W/C." "03-20-12 10:00 a.m. IDT review for falls. Fall on 03-11-12 and 03-15-12. Found in another res. room on 03-11-12 at 6:00 p.m. CP (care plan) not followed. On 03-15-12 attempted self transfer. Sensor pad added to W/C." "12-31-12 at 3:00 p.m. - Found on the floor by Restorative Aide with head up against the wheel chair. Minimal bleeding to the right (back) side of resident head scalp area. Physical assessment completed and a small laceration noted to right side (back) of head/scalp. Area cleaned and triple antibiotic ointment applied to area." "01-24-13 at 3:05 p.m. - Res. on floor from low bed to mat at side scooting on floor. assisted back to bed and no injury noted and no s/s [signs or symptoms of] pain or discomforts [sic]." The current Fall Risk Evaluation, dated 01-24-13 indicated the resident had falls in the past 3 months and the score was "12."			

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	Observation on 01-23-12 at 12:30 p.m., the resident was seated in the wheel chair in the dining room. The resident attempted to stand independently. The nursing staff redirected the resident, and assisted the resident into the wheelchair. The personal alarm did not sound at the time the resident attempted to stand. Observation on 01-24-13 at 12:10 p.m., the resident was seated in the wheel chair in the dining room. The resident attempted to stand upright from the wheel chair. The sensor alarm did not sound. When interviewed on 01-24-13 at 12:15 p.m., CNA employee #11 indicated the resident did not have the sensor pad on the chair. "[Name of resident] is suppose to have it on." Further interview on 01-24-13 at 12:30 p.m., the Unit Manager Licensed Nurse employee #5 verified the resident did not have the sensor attached to the wheel chair. The record indicated the resident fell or was found on the floor on 13 occasions. On one occasion (12-31-12) the resident sustained a head injury, another found on the			

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	floor in another resident room (03-11-12), and another the resident was found on the floor in the Activity room (03-15-12) unattended. Even though the IDT recommended the use of a sensor pad, the resident remained without the device to alert the nursing staff, and during observation, the resident did not have the device attached to the W/C to alert the staff of unassisted ambulation or transfer. 5. The record for Resident "E" was reviewed on 01-24-13 at 12:15 p.m. Diagnoses included but were not limited to, Alzheimers dementia, history of fractured hip, abnormality of gait, and dementia with behaviors. These diagnoses remained current at the time of the record review. The record indicated the resident had a previous fall on 04-20-12, in which the resident sustained a fractured hip. The IDT (interdisciplinary team) Post Fall Assessment, undated, indicated "Resident stood up from chair in DR [dining room]. Fell onto lt. [left] side. ST [skin tear] to left elbow. Yelling out and guarding right hip - x-ray obtained - hip fracture." "Contributing factors - rises unassisted, forgets to use call light, misuse/lack of adaptive			

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	device, unsteady gait, cognitive decline." The resident was transferred to a local area hospital for evaluation and treatment. Review of the Fall Risk Assessment, dated 04-24-12, and the most recent assessment, dated 01-17-13, indicated the resident was at "High Risk" for falls with a score of "18." The MDS assessment , dated 12-27-12, indicated the resident had both short term and long term memory loss with a cognitive score which indicated the resident had severe cognitive impairment. The resident was also assessed with balance difficulties and unable to regain balance without the assistance of staff members with moving from a seated to standing position, walking, turning around, moving on or off toilet, and surface to surface transfer. The plan of care, noted as "current through 04-04-13," indicated "I am at risk for fall with injury due to my impaired balance/coordination, poor safety awareness, history of falls...." Interventions to this plan of care included "keep floors in room/hallways clean, dry and free of			

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	clutter/obstacles that may impede safety while ambulating or in W/C, keep frequently use personal items within reach and in same familiar location, keep bed in low position with mat next to bed while in bed, provide toileting if restless, rolling our of bed or found on mat next to bed, staff education regarding following plan of care, perimeter mattress on bed, staff education on responding to alarm." Further review of subsequent IDT Post Fall Assessments, indicated the following: "05-04-12 Found lying on floor on back in room [number documented] - abrasion to lower back, recent fracture - no safety recall." "05-21-12 3:50 a.m. Trying to get up out of bed. Assisted to floor. Bed in low position. No injury. No safety recall. Offer snack - dress appropriately if continues to try and get oob [out of bed]." "05-26-12 4:06 p.m. Found sitting on floor in activity room. Attempted to transfer to another chair. No injury. CP [care plan] reviewed. Alarm not functioning. Batteries replaced." "05-30-12 2:45 a.m. Responded to			

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	bed alarm - found resident sitting on floor with back against bed. No apparent injury. Contributing factors - need to void. Care plan not followed as written - last toileted at 1:31 p.m. Staff education." Additional incidents as documented in the nurses notes included the following events: "09-16-12 3:32 p.m. Found in Activity Room with W/C turned upside down and alarm sounding off." "09-19-12 Found on floor next to bed in up right position." "10-14-12 2:50 p.m. Resident roommate family member alerted staff resident was climbing out of bed. Found on floor [on mat] seated position. No injury - alarm not sounding. CNA said alarm was on but not working. CNA educated to personal alarms." "11-14-12 8:33 a.m. Resident in DR and alarm sounding - unable to get to resident in time and resident went to floor on buttock. Alarm sounding and staff education on chair alarms." 12-18-12 10:46 p.m. Resident stood up unassisted from W/C while nurse			

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	was in another resident room. Resident was in the hallway lying on back to the right side of the W/C and found by another staff member." "12-29-12 11:00 a.m. Found sitting on mat next to bed with alarm going off. Had alarm in hand looking at it. No injury." "01-17-13 2:40 p.m. While in DR W/C was unlocked and chair alarm was on and nurse was standing next to kitchen window. Alarm sounded off as [resident] was standing straight up holding onto W/C. I had ahold of [resident] when legs gave out and left side leaned against my body. Found skin tear to left shoulder 4 cm by 2.5 cm." 6. The record for Resident "Q" was reviewed on 01-28-13 at 12:25 p.m. Diagnoses included but were not limited to dementia. deep vein thrombosis and vertigo. These diagnoses remained current at the time of the record review. A notation prior to the resident's admission to the facility, indicated the resident was a "fall risk" although this risk was not identified at the time of admission.			

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	Review of the admission "Fall Risk Assessment," dated 01-11-13, indicated the resident had "short term and long term memory loss, moderate cognitive impairment and poor decisions making skills. Cues and supervision required." The 01-23-13, MDS assessment indicated the resident had severe cognitive impairment. Review of the IDT notes, dated 01-25-13 at 5:35 a.m. indicated the resident was lying on floor next to bed with head next to side rail. The resident "attempted to self transfer and had decreased safety awareness, rises unassisted, forgets to use call light, had an unsteady gait. No injury." The nursing staff implemented the use of a low bed with a mat adjacent to bed and removal of the side rail. An additional fall note on 01-27-13 at 6:45 a.m. indicated the resident was "found on floor next to bed on back. Unable to state events - off mat on right side." A new intervention included "removal of the low air loss mattress and add perimeter mattress to bed." The nurses notes indicated this fall resulted in an injury of an abrasion to the right knee which			

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	measured 5.4 cm by 1.2 cm. Although the first event resulted in no injury the resident was incorrectly assessed for "Fall Risk" at the time of admission with a total score of "8." 7. The record for Resident "R" was reviewed on 01-28-13 at 12:50 p.m. Diagnoses included but were not limited to, dementia with behaviors, malaise, fatigue, difficulty in walking, hypertension and anxiety. These diagnoses remained current at the time of the record review. The Fall Risk Assessment, dated 09-05-12 indicated a score of "10," high risk for falls. The resident's MDS assessment, dated 11-21-12, indicated the resident had severe cognitive impairment and required extensive assistance with transfer and bed mobility. The Resident Summary, dated 11-22-12, also indicated the resident was "High Risk" for falls. The current plan of care indicated "I am at risk for fall with injury due to my osteoporosis, and history of compression fracture. I have dementia and delusion...."			

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	Interventions to this plan of care included "do not leave in room alone when in wheelchair." The IDT notations, dated 05-04-12 indicated the resident was "found laying on floor on back in TV/activity room - abrasion to back. Dependent for transfers." A nurses note dated 12-25-12 at 4:19 p.m. indicated the "Resident was found sitting on floor in front of W/C by family member that came and alerted staff." Observation on 0 - 1-28-13 at 12:20 p.m., the nursing staff transported the resident from the dining room and into the TV room. The resident was left unattended. The Resident Care Information Sheet lacked direction for the nursing staff not to leave the resident unattended while seated in the wheelchair. 8. The record for Resident "S" was reviewed on 01-28-13 at 8:55 a.m. Diagnoses included but were not limited to admitted with a subdural hematoma after a fall, hypertension, diabetes and dementia. These diagnoses remained current at the time of the record review.			

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Review of the hospital Discharge physician orders dated 11-06-12, indicated the resident was "high risk for falls."

The admission nursing evaluation dated 11-07-12, indicated the resident had "acute confusion, oriented to person, memory problems a history of a head injury and impaired balance." The "Fall Risk" score was "9" which indicated the resident was not at a high risk for a fall.

Review of the MDS assessment, dated 11-19-12, indicated the resident had moderate cognitive impairment, required extensive assistance with bed mobility, transfer, hygiene and toileting. In addition the assessment indicated the resident was only able to "rebalance self with the assistance of staff in regard to moving from seated to standing position, one and off toilet and surface to surface transfer."

The admission plan of care indicated, "I am at risk for falling due to left sided weakness with impaired balance, history of falling and new surrounding." Interventions to this plan of care included, non skid footwear, extensive assistance with transfer and 2 staff members, frequent reminders."

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	155198	A. BUILDING 00 B. WING	01/30/2013

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	Additional interventions, dated 11-23-12 included a low bed, mats on floor and a scoop mattress. On 12-07-12 the nursing staff provided the resident with a Dycem to the wheel chair. Review of the nurses notes indicated the resident fell or was found on the floor on the following occasions: "11-21-12 at 1:30 p.m. Balance problem while sitting - found beside bed." "11-23-12 10:24 a.m. Had been toileted and assisted to bed after lunch. Per Social Service resident up with confusion noted when fatigued. Unable to express need. Perimeter matt to be added with 2 mats on floor." "11-25-12 at 5:00 a.m. Found sitting up right beside the bed. Failure to care plan for risk factors - poor safety judgement." "12-04-12 3:15 p.m. Found on floor sitting position folding clothes - incontinent of bowel." "12-06-12 7:45 a.m. Found sitting on floor in front of wheelchair. States hit head. No s/s of redness or swelling noted to head. Failure to care plan for risk factors, unknown balance problems while			

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	standing. Care plan revision: poor safety judgement." "12-08-12 9:20 a.m. Resident fell at 9:20 a.m. No injuring (sic)." "12-10-12 8:14 a.m. CNA was walking in resident room as (resident) was getting on floor - no injury noted denies hitting head and on low mat when fall completed." "12-13-12 11:30 p.m. Attended fall - head injury - ER visit. Next to bed crossing under roommates bed - lifting head and striking head on corner of roommates foot board. 5 millimeter in size cut on left side of head with bright red blood - steristrips applied." The resident was transported to the local area hospital for evaluation and treatment. The resident returned to the facility with the use of a cervical collar due to "neck injury." "01-12-13 Found on floor in bathroom at 5:20 a.m. by CNA. Resident on left side in fetal position. Stated was trying to go to the bathroom. Stated head and neck hurt. During assessment the resident c/o [complained of] feeling dizzy. then stated needed to urinate and reach for the trashcan. Aids assisted onto the toilet. Aides [CNA'S] said, 'come here,			

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	[resident] falling asleep on the toilet. This writer went to assess and appeared lethargic and difficult to understand. The began to lean over and going in and out of consciousness. At 0530 [5:30 a.m.] this writer called 911. Resident left facility via ambulance." The resident returned to the facility and the discharge disposition form, dated 01-12-13 indicated the resident had "pain/trauma - this patient should never ambulate without a walker." Although the nursing staff provided a soft touch call light, low bed with mats on floor and a scoop mattress, the facility failed to ensure the nursing staff was alerted of unassisted ambulation or transfer. 9. Observation on 01-28-13 at 12:40 p.m., Resident "L" was transported to the TV/Activity room by the nursing staff after lunch. The resident was left unattended in this room. Review of the Resident Care Information Sheet instructed the nursing staff in capital letters "DO NOT LEAVE UP IN W/C UNATTENDED." 10. During the initial tour of the facility on 01-23-13 at 9:50 a.m., with the			

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	Director of Nurses in attendance, the Director indicated as she reached to the doorframe of a resident room, "I hate these things." When interviewed what she was referring to the Director of Nurses displayed a magnet which had the picture of a star on it and indicated the facility didn't use the magnets any longer. Only one room was observed with this magnet during the initial tour. Observation on 01-24-13 at 8:45 a.m., multiple resident rooms were observed with a bright yellow star adjacent to the resident name. When interviewed at 8:50 a.m. Certified Nurses Aides employees #7 and #8, indicated they were unaware of what the "star" meant, "but they weren't there yesterday." CNA employee #8 indicated, "I think it has something to do with thickened liquids." Interview on 01-24-3 at 9:00 a.m. Licensed Nurse employee #9 indicated she didn't know what the stars indicated as "they weren't there yesterday." Licensed Nurse employee indicated she would "go and ask someone." The Licensed Nurse returned and indicated "it is the new way to identify the resident was a fall risk." Interview on 01-24-13 at 9:30 a.m., the			

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	Director of Nurses acknowledged the "stars" were not on the resident's nameplate yesterday and further indicated the "stars" meant the resident was at risk for falls, but not necessarily a "high fall risk." "In the interest of the cost we changed from the magnets. When the resident's are admitted we observe for 72 hours for risk of falls due to new environment, we also complete a fall risk assessment quarterly, annually and with any significant change." Interview on 01-28-13 at 12:00 p.m., CNA employee #12 and Housekeeper employee #14 indicated they were unaware of the "star" adjacent to the name of the resident. Review of the Resident Care Information Sheet on 01-24-13 at 10:30 a.m., identified the following residents as a "fall risk," but did not have a "star" on the nameplate or Resident Care Information Sheet to alert the staff of the resident risk. These resident's included "G", "H", "I", "J", "K", "L", "M", "N", "O" and "P." 11. Review of the facility policy on 01-24-13 at 8:30 a.m., titled "Marquette Health Care Center Falling Star Program," and dated as "approved 04-27-07, indicated the following:			

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	"POLICY: It is the policy of Marquette, in accordance with the Fall Prevention and Management policy, to ensure a safe environment with least restrictive measures while promoting the highest possible level of independence, function and quality of life." "PURPOSE: The Falling Star program is designed to identify those residents who are at an above average risk of falls as identified by assessment, history of falls and who displays frequent falls." "DEFINITION: A star will be placed on the Resident Information Sheet or outside the door of a resident who has been identified as being at high risk for falls. All staff will be alert to the resident's specific needs as addressed on the care plan and observe frequently to prevent recurrent falls." "CRITERIA: Any resident who is a new admit with a documented history of falls, any resident who falls resulting in serious injury (e.g. fracture), any resident with two or more falls in a 30 day period... ." "STAFF DEVELOPMENT: All newly hired staff will receive training in the Falling Star program, All licensed staff will receive training in assessment and			

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	implementation of program, Ongoing monitoring and training will be provided." 12. Review of the facility policy on 01-24-13 at 8:30 a.m., titled "FALL PREVENTION AND MANAGEMENT," and dated as "approved 10-26-07," indicated the following: "PURPOSE: A Fall Prevention Program is used to provide a safe environment for residents of the Health Care Center. This program is designed to identify residents at risk of falls; define interventions for the prevention of falls; implement Quality Assurance measures to monitor progress; and provide ongoing staff education." "DEFINITION: A fall is when a resident comes to rest unintentionally on the floor. An assisted fall is a fall, A fall without injury is a fall. When a resident is found on the floor the conclusion is that a fall has occurred. If a resident rolls off a bed, including onto a mat, this is a fall." "ADMISSION: 1.) All residents will be assessed for risk of falling. 2.) The assessment will be completed upon admission, quarterly, annually, and/or if a			

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	change in condition requiring completion of a new MDS (Minimum Data Set Assessment) occurs. (Significant Change MDS) [sic]. The assessor will focus on risk facts such as pain, vision, dementia, history of fall and medications. 3.) The initial Care Plan will address interventions based on the Risk Assessment results. 4. All residents should be considered at risk for falls for 72 hours following admission due to change in environment. 6.) Residents who are identified as high risk will be planned and individualized precautions will be noted to avoid falls. 7. CNA (certified nurses aides) assignment sheets will reflect resident at high risk for falls." This Federal tag relates to Complaint Number IN00122567. 3.1-45(a)(2)			